HEALTH CARE ADVISORY BOARD

Meeting Summary
April 29, 2014

MEMBERS PRESENT
Marlene Blum, Chairman
Rose Chu, Vice Chairman
Bill Finerfrock, Vice Chairman
Dr. Tim Yarboro
Ann Zuvekas
Ellyn Crawford
Rosanne Rodilosso
Dave West

STAFF
Sherryn Craig

GUESTS
Pat Harrison, Deputy County Executive for Human Services
Brenda Gardiner, Department of Administration for Human Services
Jess Werder, Office of the County Executive
Gloria Addo-Ayensu, MD, MPH, Health Department
Rosalyn Foroobar, Health Department
Arsenio DeGuzman, Health Department
Robin Mullet, Health Department
Dr. Jean Glossa, CHCN
Michael Forehand, Inova Health System

Call to Order
The meeting was called to order by Marlene Blum at 7:40 p.m.

March Meeting Summary
The minutes were approved as submitted.

Administrative
Marlene Blum reminded HCAB members about the Healthy Community Design Summit on May 6 featuring keynote speaker, Mark Fenton. Members should have received an invitation and are encouraged to attend.

Health Care Safety Net Structure and Implementation Strategies
Marlene Blum prefaced the presentation by stating that the HCAB would not receive the consultant's full report as it must first be presented to the Board of Supervisors (BOS).

Pat Harrison, Deputy County Executive (DCE) for Human Services, provided an overview/highlights of the Safety Net Services Study. The County selected Health Management Associates (HMA) to conduct the study.

HMA was tasked with developing an implementation plan and strategies based on local and national conditions affecting safety net services in Fairfax. The stated goals of the study included:

- Building on the strengths of the County system for efficient and effective partnerships with other community providers.
- Assuring a rational, equitable, transparent approach to build and deliver a seamless system of care.
- Establishing a financially sustainable model that avoids both gaps and duplications.
- Building up what all providers (e.g., government, nonprofit, for profit) bring to realize the vision for an integrated health care delivery system.
- Supporting an effective infrastructure, including care management and information technology.

HMA has completed its review of the safety net system and developed recommendations for implementing a Health Care Collaborative. These strategies will be presented to the Board of Supervisors (BOS) Human Services Committee on May 6.

Local, state, and national conditions that precipitated the study included the:

- Affordable Care Act;
- Strain on existing safety net providers, including increasing demands for services, increasing costs to provide services, and an overall need for system-wide efficiencies to reduce costs and improve outcomes;
- Changing practices in health care, including an emphasis on practice and systems integration;
- Changing role for public health with community health partners providing most health services; and
- Lack of a systems response to the changing environment.

Three years ago, the county convened the Health Care Reform Task Force to review the impact of federal and state health reform efforts and opportunities. At that time, George Mason University (GMU) completed a thorough service and program inventory (e.g., capacity, cost, operations) of health care safety net services operating in Fairfax County. It was estimated that 144,000 residents were uninsured, with 50% anticipated to obtain coverage through the Federal health insurance marketplace and Medicaid expansion for adults.

Key recommendations from GMU included:

- Partnership between county and community providers for integrated health care;
- Inclusion of oral, behavioral, pharmacy, specialty and primary care and integration of health safety net services;
- Streamline eligibility processes internally; and

- Cross-system information technology solutions to support integrated health care service delivery.

The county took these recommendations to heart and continues to study their feasibility.

HMA studied the entire safety net system – its strengths and weaknesses, its internal and external processes. The consultant found that the current system is "siloed;" it's not integrated to meet the needs of our most vulnerable populations.

Several service gaps were identified in the current system:

- Health care is fragmented and is driven by program and/or funding decisions.
- Gaps in Medicaid coverage continue.
- An expansion in Virginia's Medicaid would help an estimated 30,000 Fairfax residents, but an inadequate supply of primary and specialty care providers for Medicaid and Medicare covered patients in Northern Virginia exists.
- Many residents who are uninsured are "over income" for existing local county programs.
- Demand exceeds capacity for some county provided/funded health services.

The safety net system also lacks strong systems and policies:

- A lack of system-wide planning and policy oversight continues to make integrating services difficult.
- The safety net infrastructure lacks coordination, which affects client access, service referrals, enrollment, volunteer recruitment, and technology development.
- A lack of standardized community health data hinders system planning and monitoring efforts.

Financing core safety net services remains a challenge, especially for many FQHCs.

- Diversified and coordinated funding strategies are needed for county programs in order to maximize and leverage state and federal resources.
- Better stewardship of health care funding is needed.
- Medicaid reimbursements do not cover the full costs of many services that are provided.
- There is limited availability for reduced fee/charity health care, especially among specialty care providers. Cardiology, neurology, podiatry, gastroenterology, behavioral health, and dermatology are not always available for low income, Medicaid and Medicare patients. Recruiting out-of-region providers to provide free/reduced care and increasing wait times for insured patients are neither feasible nor sustainable.

The Fairfax County Health Collaborative identified several principles in integrating its community network model with a patient-centered focus:

- Each patient should obtain comprehensive care that he or she needs.

- It should not matter what geographic area of the county a person lives in; access should be the same.
- Waiting times should be reduced and care provided in a timely way.
- Access to preventive care is crucial to reduce costs.
- Specialty care needs should be offered in our community (e.g., oncology, radiology) and low-income residents should not have to travel to state hospitals for treatment.
- Low income residents should have access to quality and affordable health care.
- There should be a shared responsibility, with resources from partners, to achieve an integrated model.

HMA validated GMU's analysis and County Action Plan, which was presented to the BOS in October 2012, and recommended strategies to implement approved actions.

HMA's proposed vision is ambitious and requires substantial action. Internally, the county must streamline its infrastructure; externally, the county must align itself around a community framework. HMA's plan around service integration will require:

- Working with providers to create a community-wide integrated delivery system for uninsured, Medicaid-covered residents, low-income residents and others facing health access barriers.
- Recognizing County-run and funded programs delivering direct medical, behavioral health and dental services to patients and creating an integrated entity that maximizes County effectiveness and allows greater access and organized participation in the community-wide network.
- Creating a health network infrastructure with community partners to serve the patients in the safety net and calling for the alignment and integration of safety net services.
- Aligning County eligibility and care management services to better manage patient access to care (i.e., front door service delivery).
- Assuring patient access to needed services is well-coordinated.
- Developing a planning and accountability framework that provides the health care "blueprint" for the county.
- Publishing a firm timeline that is monitored by County leadership to assure accountability and performance.
- Setting specific benchmarks for systems transformation.

Part of service integration also includes how the system integrates information. HMA is recommending a phased in approach to implement information and technology improvements across the system. HMA is recommending that the system establish community partner-county information technology "quick hit" data protocols to connect patients to their care providers, manage referrals among providers, and share necessary patient data.

Ms. Harrison stated that integration involves more than co-locating people. Entire systems around enrollment, access, revenue, and billing must all be coordinated.

HMA also conducted an extensive review of the system's financing strategy (or lack thereof), including Medicaid providers, how they're operating, and how access is driven. Twelve recommendations will be presented to the BOS, including seeking additional federal funding for provided services and community-wide initiatives.

Brenda Gardiner reported that conversations with Inova Health System were positive, with opportunities to strengthen what's currently in place and explore new possibilities as well. Ms. Gardiner also stated that universities are local resources that have not been leveraged, and there are ongoing discussions with the Medical Society to improve specialty care access in the community.

In terms of what the study's recommendations mean for the HCAB, Ms. Gardiner said that the board's overall role of advising the BOS on public health matters would not change. The HCAB would provide input on system-wide issues such as access, financing, health care and service plan coordination, standards of care, and clinical health records.

Ms. Harrison concluded the presentation by saying that the consultant's report will be presented to the BOS on May 6 and Board approval will be requested to approve the strategy to bring critical community providers together to establish the framework for the Community Health Collaborative and the development of a detailed operation work plan for internal realignment of services.

Ms. Gardiner outlined the next steps in the development of the Community Framework:

1. Convene work groups on information technology needs of system (address shared data, use of electronic health records, system outcomes measures) and health financing requirements.
2. Convene broader Community Health Collaborative representation, including who will be served by each stakeholder, options for care coordination, and systems outcomes/reporting/accountability.
3. County review of HMA internal alignment recommendations with a report back to the DCE in Fall 2014.
4. Presentation and input sessions for staff, boards and commissions with a focus on how BACs will network given their respective roles.

The Community Framework will provide an annual plan for the safety net. It is different from a Community Health Needs Assessment.

Ms. Harrison is committed to making sure the participant experience and their overall outcomes are better. There will be a separate work plan for BACs and consumer committees that have not yet been reached. Ms. Harrison agreed that patients are stakeholders, not just customers.

With respect to drawing down additional state and federal dollars, Ms. Harrison said that there must be a dedicated staff person – a Chief Financial Officer – identifying revenue and resource opportunities. The community is rich in resources, but it must work as a system, through strong partnerships, if it wants to position itself and take advantage of federal funding opportunities.

HCAB members expressed some concern about abandoning programs that work well locally in order to conform with federal funding requirements. For example, the federal government advocates FQHC's in order to provide care to low-income, uninsured individuals. However, Fairfax County has the CHCN; it does not need to create an FQHC. It does however need the FQHC dollars if it wants to expand CHCN.

Ms. Harrison agreed. She said that the community must try to fill existing gaps without spending more money but by realigning what's currently available.

The HCAB also commented that the deficiencies that GMU and HMA highlight extend beyond the safety net level of care; they are reflective of the larger health care delivery system.

The HCAB also suggested that instead of telling people to wait until the framework is built, some current needs should be addressed.

Ms. Harrison and Ms. Gardiner agreed saying that internally, the County must become more efficient with how it screens and enrolls clients. There is an average wait time of six weeks for behavioral health services, and that needs to be addressed immediately. A short discussion of "no wrong door" policies was discussed, and this is being explored by several jurisdictions to expand federal benefit program enrollment.

Besides internal improvements, Ms. Harrison also commented that externally, the County needs to engage the provider community using one voice.

Ms. Harrison said that the full report would be provided to the HCAB after the May 6 presentation to the BOS and that she would be happy to return to the HCAB to discuss the BOS' plans for moving forward with the Community Health Collaborative.

May HCAB Meeting

The meeting agenda for the May 12 HCAB meeting includes a public hearing on an assisted living facility/memory care community – Arbor Terrace of Fairfax – as well as presentations on accreditation and 50+ recommendations. The HCAB will also receive a short update on the FY 2015 budget, including information from EMS on the $1 million cut in large apparatus and ambulance replacements.

There being no further business, the meeting adjourned at 9:08 pm.